Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

SERVICE MODIFICATION

Provider Request

Code of Virginia §37.1-183.1

Please print legibly using permanent, black ink. The chief executive officer, director, or other member of the governing body who has the authority and responsibility for maintaining standards, policies, and procedures for the service may complete this application.

☐ **ADD A SERVICE:** THE FOLLOWING ATTACHMENTS ARE REQUIRED**:**

- ☐ A Service description, meeting all of the requirements outlined in §12 VAC 35-105-580,
- ☐ Discharge criteria as outlined in §12 VAC 35-105-860.A,
- ☐ A schedule of staffing pattern, staff credentials, §12 VAC 35-105-590,
- ☐ The proposed working budget for the first year of the service's operation, §12 VAC 35-105-40.A (1),
- ☐ Evidence of financial resources, or a line of credit sufficient to cover estimated operating expenses for the first ninety-days, §12 VAC 35-105-40.A (2),
- ☐ Copies of ALL position descriptions, §12 VAC 35-105-410,
- ☐ Certificate of occupancy for the physical plant, §12 VAC 35-105-260,
- ☐ Verification that new service is affiliated with local human rights committee and the current human rights policies and procedures are approved, §12 VAC 35-105-150.4,

And for residential services,

- ☐ A current health inspection (if not on public water or sewage), §12 VAC 35-105-580
- ☐ A current fire inspection (if housing more than 8 residents), §12 VAC 35-105-320, and
- ☐ A floor plan with dimensions (for residential facilities), §12 VAC 35-105-40.B (5).

☐ **ADD A LOCATION:** THE FOLLOWING ATTACHMENTS ARE REQUIRED**:**

- ☐ Notification of address, proposed opening date,
- ☐ A schedule of staffing pattern, staff credentials, §12 VAC 35-105-590
- ☐ Certificate of occupancy, §12 VAC 35-105-260
- ☐ Verification that new service is affiliated with local human rights committee and current human rights policies and procedures are approved. §12 VAC 35-105-150.4,
- ☐ The proposed working budget for the first year of the service's operation. §12 VAC 35-105-40.A (1),
- ☐ Evidence of financial resources, or a line of credit sufficient to cover estimated operating expenses for the first ninety-days, §12 VAC 35-105-40.A (2),

And for residential services,

- ☐ A current health inspection (if not on public water or sewage), §12 VAC 35-105-580
- ☐ A current fire inspection (if housing more than 8 residents), §12 VAC 35-105-320, and
- ☐ A floor plan with dimensions (for residential facilities), §12 VAC 35-105-40.B (5).

Other Modifications:

☐ Population Served (Age, Gender, Disability)
☐ Add a Track to Current Service
of beds or capacity
☐ Service Description
☐ Name change
☐ Address change
☐ Telephone number change
☐ Other:_____
☐ Number

INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE PROVIDER

1.Applicant Information: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Organization
Name:_____

License #: _____

Mailing
Address_____

City:_____ County _____State:_____

Zip:_____ Phone:( )_____

Chief Executive Office or Director. Identify the person responsible for the overall management and oversight of the service(s) and facility(s) to be operated by the applicant.

Name:_____Title:_____

Phone: ( )_____ Fax Number: ( )_____Email: _____

SERVICE INFORMATION

Using the list below, place an **X** by the service type(s). If the service type(s) is not listed, please note in the service information section.

* **Residential Services**
- ☐ Community ICF-MR
- ☐ Community Gero-psychiatric
- ☐ Crisis Stabilization
- ☐ Group Home
- ☐ Half-Way House
- ☐ Medical Detox and Social Detox
- ☐ Residential Community Services
- ☐ Residential Respite
- ☐ Residential Treatment
- ☐ Residential Treatment SA women w/children
- ☐ Supervised Living

* **Day Support Services**
- ☐ Clubhouse
- ☐ Day Support
- ☐ Day Treatment
- ☐ Intensive Outpatient
- ☐ Partial Hospitalization/Ambulatory Detox
- ☐ Psychosocial Rehabilitation
- ☐ Therapeutic After-School
- ☐ Center-Based Respite

* **Supported In-Home Services (formerly supportive residential)**
- ☐ In-Home Services
- ☐ In-Home and Out-of home Respite
- ☐ Mental Health Community Support Services
- ☐ Crisis Stabilization

* ☐ **Case Management Services**

* ☐ **Inpatient Services**
- ☐ Psychiatric Unit
- ☐ Medical Detox/CD Unit

* ☐ **Intensive In-Home Services**

* ☐ **Opioid Treatment Services**

* **Outpatient Services**
- ☐ Outpatient
- ☐ Emergency

* ☐ **Sponsored Residential Home Services**

* ☐ **Department of Corrections Facilities Services**

* ☐ **Intensive Community Services (ICT)**

* ☐ **Programs for Assertive Community Treatment (PACT)**

4.Service Information: Complete for each service type offered by the organization to be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services. (See listing of services types.)

Service Type:_____

Service Director _____Phone ( ) _____

THIS SERVICE SERVES:

Individuals with single diagnosis (check all that apply):
- [] Mental Retardation
- [] Mental Illness
- [] Substance Abuse

AND/OR

Individuals with multiple diagnoses (check all that apply):
- [] Mental Illness/Mental Retardation
- [] Mental Retardation/Substance Abuse
- [] Mental Illness/Substance Abuse
- [] Mental Illness/Mental Retardation/Substance Abuse

[] Individuals receiving services through the Individual and Family Developmental Disabilities Support Waiver

Individual Demographics (check all that apply):
[] Male [] Female [] Child [] Adolescent [] Adult [] Geriatric

Accreditation/Certification by:_____

Location(s)

1.**Location Name**:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____Phone:( )_____

Directions:_____

_____

2. **Location Name**:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____ Phone:( )_____

Directions:_____

_____

3. **Location Name**:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____ Phone:( )_____

Directions:_____

_____

Certificate of Application

This certificate is to be read and signed by the applicant. The person signing below must be the individual applicant in the case of a proprietorship or partnership, or the chairperson or equivalent officer in the case of a corporation or other association, or the person charged with the administration of the service provided by the appointing authority in the case of a governmental agency.

I am in receipt of and have read the applicable rules and regulations for licensing. It is my intent to comply with the statutes and regulations and to remain in compliance if licensed.

I grant permission to authorized agents of the Department of Mental Health, Mental Retardation and Substance Abuse Services to make necessary investigations into this application or complaints received.

I understand that unannounced visits will be made to determine continued compliance with regulations.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

Signature of Applicant: _____ Date:_____ Title:_____

If you have any questions concerning the application please contact this office at (804) 786-1747. This application is to be returned to:

Office of Licensing
Department of Mental Heath, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797